

## MATERNAL AND CHILD HEALTH BUREAU

<b>SUMMARY PROGRESS REPORT</b> <b>MCHB PROGRAM/CATEGORY: <u>SPRANS</u></b> <b><u>SSDI</u></b> <b>CFDA NUMBER: <u>93.110W</u></b>	<b>GRANT NUMBER</b> <b><u>6H18MC-</u> <u>-08</u></b>
APPLICANT ORGANIZATION  NAME:  ADDRESS:   TELEPHONE :	PROJECT DIRECTOR OR PRINCIPAL INVESTIGATOR  NAME:  TELEPHONE :  E-MAIL:  FAX:
TITLE OF PROJECT:	NEXT BUDGET PERIOD REQUESTED:  FROM: 10-1-2000                      TO: 9-30-2001

CHANGES IN STATUS OF GRANTEE INSTITUTION, e. g. , NAME CHANGE, MERGER, DIVESTITURE

(   ) YES

(   ) NO

PROGRESS REPORT DUE DATE: to be received on or before July 14, 2000

THE FOLLOWING ASSURANCES/CERTIFICATIONS ARE MADE, FILED, AND VERIFIED BY THE SIGNATURE OF THE OFFICIAL SIGNING FOR APPLICANT ORGANIZATION ON THE FACE PAGE OF THE APPLICATION. IF THERE ARE ANY CHANGES, PROVIDE AN EXPLANATION AND PLACE IT AFTER THIS PAGE.

HUMAN SUBJECTS; VERTEBRATE ANIMALS; DEBARMENT AND SUSPENSION; LOBBYING; DELINQUENT FEDERAL DEBT; RESEARCH MISCONDUCT; CIVIL RIGHTS (FORM HHS 441 OR HHS 690); HANDICAPPED INDIVIDUALS (FORM HHS 641 OR HHS 690); SEX DISCRIMINATION (FORM HHS 639-A OR HHS 690); AGE DISCRIMINATION (FORM HHS 680 OR 690)

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS PROGRESS REPORT ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ABOVE-MENTIONED ASSURANCES/CERTIFICATIONS IF THE ASSISTANCE IS AWARDED.

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TYPED NAME OF AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
TELEPHONE

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED REPRESENTATIVE

\_\_\_\_\_  
DATE SIGNED